

Early Intervention Program

Prescriptions-APDP Medical Insurance Spenddown

If you have questions, please call us at 1-877-376-9316.

What is the Early Intervention Program (EIP)?

EIP is a program of the Washington State Department of Health in Olympia. We help persons with HIV who live in Washington by paying for:

- **Prescription medications on our formulary.** If you have insurance, we can assist with co-pays.
- **Limited doctor visits and tests.** If you have insurance, we can assist with deductibles and pre-exist periods. You must go to a provider contracted with us.
- **Insurance premiums in certain situations.**
- **Spenddown to get Medicaid coverage** (up to a certain level).

Do you have to pay anything for these services?

Clients with incomes over 125% (\$923 in 2002) who have EIP as their only health care coverage will pay a monthly fee to get medications. This fee is based on income and ranges between \$40 and \$60 per month.

How do you apply?

- Complete this application.
- Collect any required documents.
- Mail the application and documents to the EIP address on the application.

We do not accept faxed applications.

How will we process your application?

- If your application is **complete**, we will send you a letter describing your eligibility. Your coverage will begin on the first day of the month your application is postmarked. Normally, your coverage will last for one year.
- If your application is **not complete**, we will send you a letter telling you what we need.
- If your income is under 125% of Federal Poverty Level (\$923 for a single person in 2002) you must also apply for Medicaid. We will send you a Medicaid application if you have not already applied.

A note about confidentiality

We will talk with your case manager or health care provider about your eligibility. We will not talk to anyone else (family, friend) unless you give us a signed statement listing whom we may talk to.

Early Intervention Program Confidential Application

Prescriptions-APDP Medical Insurance Spenddown

If you have questions or would like to receive this application in an alternative format, call us at **1-877-376-9316**. You may also reach us through the state TDD Relay Service at 1-800-833-6388.

Send this completed application and required documents to:

If you want to send your application through an overnight service, call us to get our physical address.

Early Intervention

Program

PO Box 47841

Olympia WA 98504-7841

1. How did you first hear about our program? Check only one.

☐ Case manager ☐ Health care provider ☐ Friend ☐ Other _____

2. Please tell us about you:

Last name First name Middle initial Phone number

Mailing address City State Zip code County

Note: If your mailing address is a Post Office Box, you must also list the address where you live:

Home address City State Zip code County

Birth date Social Security # (optional) ☐ Female ☐ Male

Answer Part 1 **and** Part 2:

Part 1: Are you Hispanic or Latino? ☐yes ☐no

and

Part 2: Check all of the following that apply:

- ☐ American Indian/Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian/other Pacific Islander
☐ White
☐ Other _____

Have you tested positive for HIV? ☐yes ☐no

Are you disabled by your HIV? ☐yes ☐no

3. Would you like to receive future renewal applications in Spanish? ☐yes ☐no

4. Do you have a case manager? ☐yes ☐no

What is your case manager's name? _____

What is your case manager's phone number or agency? _____

5. Check any of these resources that you have.

- | | |
|---|---|
| <input type="checkbox"/> Cash, savings, checking | <input type="checkbox"/> Real estate (not counting the home where you live) |
| <input type="checkbox"/> Trust fund | <input type="checkbox"/> Stocks and bonds |
| <input type="checkbox"/> Annuities | <input type="checkbox"/> Other items of value _____ |
| <input type="checkbox"/> Vehicles and recreational vehicles (not counting one automobile) | |

6. What is the total value of your resources (do not leave blank)? \$ _____

7. Do you have monthly income? ☐yes ☐no

→ If you said "no", explain how you support yourself: _____

→ If you said "yes", you must complete this section.

1. Check a box for each type of income you get.
2. Write on the line how much you get each month before taxes are taken out.
3. Send verification of each income.

- | | |
|--|----------|
| <input type="checkbox"/> Wages, salary, commissions, tips | \$ _____ |
| <input type="checkbox"/> Unemployment compensation | \$ _____ |
| <input type="checkbox"/> Social security, SSI or SSDI | \$ _____ |
| <input type="checkbox"/> Other disability income, including trust funds for disability | \$ _____ |
| <input type="checkbox"/> Veteran's benefits | \$ _____ |
| <input type="checkbox"/> Retirement, pensions, annuities | \$ _____ |
| <input type="checkbox"/> Self employment | \$ _____ |
| <input type="checkbox"/> Other sources – list: _____ | \$ _____ |

Income verification

Wages: check stub

Self-employment:
check stub, business records, or something that shows how much you earn

All other: check stub, benefits statement, or bank statement showing direct deposit

8. On your most recent tax form, did you report income from interest, ordinary dividends, or capital gains over \$500? ☐yes ☐no

If yes, send a copy of your most recent IRS Form 1040 and all attachments.

9. What health care coverage do you have? Check all that apply.

☐ Veteran's benefits

If yes, call our office for more information.

☐ DSHS Medicaid

Do you have a spenddown? ☐ yes ☐ no

☐ Medicare

☐ Medical insurance

What is the name of your insurance company? _____

What is the phone number of your insurance company? _____

Is this insurance: ☐ WSHIP ☐ BHP ☐ Medicare supplement

Are you in a pre-existing condition wait period? ☐ yes ☐ no ☐

If yes, when does your pre-exist period end? _____

10. Where do you go for medical care?

Providers name _____ Clinic name _____

City _____ Phone number _____

Required	<p>The information on this form is true and complete to the best of my knowledge. I understand that giving false information is against the law. I also understand that if I give false or inaccurate information or fail to notify you of changes in a timely manner, I may lose benefits and I may be required to pay them back.</p> <p>Your signature _____ Date _____</p>
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Required	<p>We keep your records secure and confidential. To provide services to you, we must talk with your medical providers and share information.</p> <p>I give my permission for the Early Intervention Program and my health care providers, including my case manager and DSHS, to share information about my medical care and insurance coverage. I give this permission for one year and 60 days.</p> <p>Your signature _____ Date _____</p>
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Optional	<p>We want to make sure all our clients receive high quality services. One way we do this is to link your information with hospital, infectious disease case reports, and special research datasets. You can receive services even if you choose not to sign this statement.</p> <p>I give my permission to link identifying information from my records to other public health records in the Department of Health's Office of Infectious Disease and Reproductive Health to evaluate the way services are provided, the benefits the program provides, and the program's impact on the health of the community.</p> <p>Your signature _____ Date _____</p>
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